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MEDICARE PHYSICIAN GROUP PRACTICE DEMONSTRATION

Physicians Groups Continue to Improve Quality and Generate Savings Under Medicare Physician Pay-for-Performance Demonstration

The Physician Group Practice (PGP) Demonstration is the first pay-for-performance initiative for physicians under the Medicare program. The demonstration creates incentives for physician groups to coordinate the overall care delivered to Medicare patients, rewards them for improving the quality and cost efficiency of health care services, and creates a framework to collaborate with providers to the advantage of Medicare beneficiaries. Mandated by Section 412 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, the goals of the demonstration are to:

- Encourage coordination of Part A and Part B services;
- Promote cost efficiency and effectiveness through investment in care management programs, process redesign, and tools for physicians and their clinical care teams; and
- Reward physicians for improving health outcomes.

Under the five year demonstration, the Centers for Medicare & Medicaid Services (CMS) rewards physician groups for improving patient outcomes by proactively coordinating their patients' total health care needs, especially for beneficiaries with chronic illness, multiple comorbidities, and transitioning care settings. Since they will share in any financial savings that result from improving the quality and cost efficiency of care, the groups have incentives to integrate new care management strategies and electronic tools into day-to-day practice that, based on clinical evidence and patient data, improve patient outcomes and lower total medical costs. These strategies are designed to anticipate patient needs, prevent chronic disease complications and avoidable hospitalizations, and improve quality of care.

Demonstration Overview

Under the demonstration, physician groups continue to be paid under regular Medicare fee schedules and may share in savings from enhancements in patient care management. Physician groups may earn performance payments of up to 80% of the savings they generate. The Medicare Trust Funds retain at least 20% of the savings. Performance payments are divided between cost efficiency for generating savings and performance on 32 quality measures phased in during the demonstration. As quality measures were added in performance years two and three, the quality portion has increased so that in the third performance year 50% of any

performance payment is for cost efficiency and 50% is for achieving national benchmarks or improvement targets on quality.

At the end of each performance year, total Medicare Part A and Part B per capita spending is calculated for assigned beneficiaries and compared to a base year period to calculate an assigned beneficiary growth rate. Physician group practices whose Medicare spending growth rate for assigned beneficiaries is more than 2 percentage points lower than their comparison population may share up to 80% of Medicare savings. The comparison population is derived from each physician group's local market area. Total Medicare Part A and Part B per capita spending is calculated for Medicare beneficiaries residing in the local market area who did not have an office visit at the physician group during the performance year and compared to a base year period to calculate the local market area growth rate.

Medicare beneficiaries are assigned to each group if the group provided the plurality of their office or other outpatient evaluation & management services during the performance year. On average, assigned beneficiaries have five visits at the physician group during the year.

Expenditures are risk-adjusted, since the growth in per beneficiary spending can be affected by changes in case-mix, or the health status, of the beneficiaries in a group. The demonstration uses the CMS-HCC concurrent risk adjustment model which uses current year diagnoses to adjust current year expenditures. Using concurrent risk adjustment in the demonstration provides an accurate assessment of changes in the health status of beneficiaries.

Measuring Quality

Effective pay-for-performance systems require effective measures of performance as their foundation. The ambulatory care measures used under the demonstration are part of Medicare's comprehensive efforts to improve the quality of care delivered to Medicare beneficiaries. The measures were developed by CMS working in an extensive process with the American Medical Association's Physician Consortium for Performance Improvement and the National Committee for Quality Assurance (NCQA). The measures have undergone review or validation by the National Quality Forum, which provides endorsement of consensus-based national standards for measurement and public reporting of healthcare performance data.

CMS worked with the physician groups to develop a consensus agreement on how to report the measures and how to use them to assess performance and reward quality under the demonstration. The measures were phased in starting with the diabetes mellitus measures that were used to assess performance and reward quality care during the first performance year. Additional measures focusing on congestive heart failure and coronary artery disease were added in performance year two. Hypertension and cancer screening measures were added for performance years three, four and five.

The demonstration rewards groups that improve and deliver high quality care. National benchmarks and group specific quality improvement targets are used to provide incentives for quality improvement as well as to recognize groups that are achieving high levels of

performance. Combining national benchmarks and quality improvement targets provide for achievable benchmarks for care.

Given their extensive focus on quality under the demonstration, the physician groups agreed to place their incentive payments under CMS's Physician Quality Reporting Initiative (PQRI), a pay for reporting initiative, at risk for performance on the quality measures reported under the demonstration. As a result, the groups receive PQRI incentive payments based on their overall quality performance under the demonstration.

CMS recently announced that other large physician groups may use this reporting process and similar measures to participate in the PQRI pay for reporting initiative starting in 2010.

| Physician Group Practice Demonstration Quality Measures | | | |
|---|--|---|-------------------------------------|
| Diabetes Mellitus | Congestive Heart Failure | Coronary Artery Disease | Preventive Care |
| HbA1c Management | Left Ventricular Function Assessment | Antiplatelet Therapy | Blood Pressure Screening |
| HbA1c Control | Left Ventricular Ejection Fraction Testing | Drug Therapy for Lowering LDL Cholesterol | Blood Pressure Control |
| Blood Pressure Management | Weight Measurement | Beta-Blocker Therapy – Prior MI | Blood Pressure Control Plan of Care |
| Lipid Measurement | Blood Pressure Screening | Blood Pressure | Breast Cancer Screening |
| LDL Cholesterol Level | Patient Education | Lipid Profile | Colorectal Cancer Screening |
| Urine Protein Testing | Beta-Blocker Therapy | LDL Cholesterol Level | |
| Eye Exam | Ace Inhibitor Therapy | Ace Inhibitor Therapy | |
| Foot Exam | Warfarin Therapy for Patients HF | | |
| Influenza Vaccination | Influenza Vaccination | | |
| Pneumonia Vaccination | Pneumonia Vaccination | | |

Physician Group Practices

CMS selected ten physician groups on a competitive basis to participate in the demonstration. The groups were selected based on technical review panel findings, organizational structure, operational feasibility, geographic location, and demonstration implementation strategy. Multi-specialty physician groups with well-developed clinical and management information systems were encouraged to apply since they were likely to have the ability to put in place the infrastructure necessary to be successful under the demonstration.

The demonstration allows CMS to test new incentives in diverse clinical and organizational environments including freestanding multi-specialty physician group practices, faculty group practices, physician groups that are part of integrated health care systems, and physician network organizations. The demonstration has fostered a nation-wide learning collaborative among the

groups who voluntarily participate in this demonstration as a result of their leadership in their communities and profession. CMS is working with the groups to identify successful health care redesign and care management models developed for the demonstration that can be replicated and spread across the health care system.

The ten physician groups represent 5,000 physicians and 220,000 Medicare fee-for-service beneficiaries. The physician groups participating in the demonstration are:

Billings Clinic, Billings, Montana
Dartmouth-Hitchcock Clinic, Bedford, New Hampshire
The Everett Clinic, Everett, Washington
Forsyth Medical Group, Winston-Salem, North Carolina
Geisinger Health System, Danville, Pennsylvania
Marshfield Clinic, Marshfield, Wisconsin
Middlesex Health System, Middletown, Connecticut
Park Nicollet Health Services, St. Louis Park, Minnesota
St. John's Health System, Springfield, Missouri
University of Michigan Faculty Group Practice, Ann Arbor, Michigan

Performance Results

Performance Year 1 Results -- At the end of the first performance year, all 10 of the participating physician groups improved the clinical management of diabetes patients by achieving benchmark or target performance on at least 7 out of 10 diabetes clinical quality measures. Two of the physician groups -- Forsyth Medical Group and St. John's Health System -- achieved benchmark quality performance on all 10 quality measures.

In performance year one, two physician groups shared in savings for improving the overall efficiency of care they furnish their patients. The two physician groups, Marshfield Clinic and the University of Michigan Faculty Group Practice, earned \$7.3 million in performance payments for improving the quality and cost efficiency of care as their share of a total of \$9.5 million in Medicare savings.

Performance Year 2 Results -- At the end of the second performance year, all 10 of the participating physician groups continued to improve the quality of care for chronically ill patients by achieving benchmark or target performance on at least 25 out of 27 quality markers for patients with diabetes, coronary artery disease and congestive heart failure. Five of the physician groups -- Forsyth Medical Group, Geisinger Clinic, Marshfield Clinic, St. John's Health System, and the University of Michigan Faculty Group Practice -- achieved benchmark quality performance on all 27 quality measures.

In performance year two, four physician groups shared in savings for improving the overall efficiency of care they furnish their patients. The four physician groups, Dartmouth-Hitchcock Clinic, The Everett Clinic, Marshfield Clinic, and the University of Michigan Faculty Group Practice, earned \$13.8 million in performance payments for improving the quality and cost efficiency of care as their share of a total of \$17.4 million in Medicare savings.

Performance Year 3 Results -- At the end of the third performance year, all 10 of the participating physician groups continued to improve the quality of care for patients with chronic illness or who require preventive care by achieving benchmark or target performance on at least 28 out of 32 quality markers for patients with diabetes, coronary artery disease, congestive heart failure, hypertension, and cancer screening. Two of the physician groups -- Geisinger Clinic and Park Nicollet Health Services -- achieved benchmark quality performance on all 32 quality measures.

In addition to achieving benchmark performance for quality, five physician groups shared in savings under the demonstration's performance payment methodology. The five physician groups, Dartmouth-Hitchcock Clinic, Geisinger Clinic, Marshfield Clinic, St. John's Health System, and the University of Michigan Faculty Group Practice, earned \$25.3 million in performance payments for improving the quality and cost efficiency of care as their share of a total of \$32.3 million in Medicare savings.

Performance Year 4 Results -- In performance year 4, all ten of the physician groups achieved benchmark performance on at least 29 of the 32 measures. Three groups -- Geisinger Clinic, Marshfield Clinic, and Park Nicollet Health Services achieved benchmark performance on all 32 performance measures and all ten of the groups achieved benchmark performance on the ten heart failure and seven coronary artery disease measures.

The PGPs have increased their quality scores from baseline to performance year 4 an average of 10 percentage points on the diabetes measures, 13 percentage points on the heart failure measures, 6 percentage points on the coronary artery disease measures, 9 percentage points on the cancer screening measures, and 3 percentage points on the hypertension measures.

In addition to the quality performance, five physician groups -- Dartmouth-Hitchcock Clinic, Geisinger Clinic, Marshfield Clinic, St. John's Health System, University of Michigan -- earned incentive payments based on the estimated savings in Medicare expenditures for the patient population they serve. The groups received performance payments totaling \$31.7 million as their share of the \$38.7 million of savings generated for the Medicare Trust Funds in performance year 4.

Care Management Strategies

One of the unique features of this demonstration is that physician groups have the flexibility to redesign care processes, invest in care management initiatives, and target patient populations that can benefit from more effective and efficient delivery of care. This helps Medicare beneficiaries maintain their health and avoid further illness and admissions to the hospital. The following provides an overview of the quality and efficiency innovations underway at each demonstration site.

Billings Clinic focuses on providing evidence-based care, including preventive services, at the time of each patient visit. This is accomplished by the creation of a summary that identifies gaps in care and redesigning workflow for nursing and support staff. An example is the improved

management of patients with diabetes through the use of a diabetes patient registry, electronic medical record modules, a team of diabetes experts/educators offering a patient friendly report card, and a pharmacy driven insulin protocol for glycemic control in the inpatient setting. As a result of these efforts focused on diabetes care, a majority of the clinic's eligible physicians have been recognized through NCQA's Diabetes Physician Recognition Program for excellence in diabetes care. The Clinic also continues efforts to: (1) redesign heart failure care by leveraging an RN-directed telephonic computerized patient monitoring system; (2) decrease medication errors by using electronic prescribing and reconciling medications at every care opportunity; (3) expand the palliative care team; and (4) develop a community crisis center to benefit dual eligible patients with mental health related events. For more information, contact: F. Douglas Carr, M.D. at dcarr@billingsclinic.org.

Dartmouth-Hitchcock Clinic focuses on improving quality while reducing costs through implementation of evidence-based care initiatives. The clinic uses recognized experts to educate physicians and support staff in understanding evidence-based care guidelines. Electronic tools and reports including disease registries, dashboard reports to track progress on quality measures, and electronic medical record enhancements are used by the physicians and staff at the point of patient contact to proactively identify patients with gaps in chronic disease care and focus on preventive care. Evidence-based care implementation also requires changing workflow processes and roles for support staff. For example, in the primary care departments, the physician and nurse work together to provide a patient centered approach to care highlighted by patient and family involvement in developing and implementing the plan of care. Care is coordinated by nurses who target interventions to high-risk patients using motivational education on disease and personal health care through in-office visits and/or post hospital discharge phone calls. For more information, contact: Barbara Walters, D.O. at Barbara.A.Walters@Hitchcock.org.

The Everett Clinic is improving health care delivery to seniors by: (1) providing electronic patient reports to primary care physicians to use in addressing issues with diabetes, heart disease, hypertension, and mammogram and colonoscopy screening results; (2) coaching hospitalized patients and caretakers to guide them through complicated care processes during hospital stays and upon discharge; (3) having physicians follow-up with patients within ten days of hospital discharge to address any unsolved or new health problems; (4) partnering with local providers to deploy new palliative care programs in physicians' offices to improve end-of-life care for approximately 800 patients; (5) making delivery of primary care services more efficient and patient-friendly by removing non-value-added steps ("lean principles"); and (6) implementing evidence based guidelines to improve appropriateness for ordering radiology imaging tests. For more information, contact: James Lee, M.D. at Jlee@everettclinic.com.

Forsyth Medical Group focuses on care coordination at transitions of care to promote safe, patient-centered services. Concentration on the frail elderly, high risk diseases and polypharmacy issues identifies those patients at greatest risk for readmission and adverse events associated with multiple therapies. COMPASS Disease Management Navigators and Safe Med Pharmacists collaborate with inpatient services and systems to identify these at risk populations. Programs target inpatient discharges to assess the patient's understanding and adherence to

discharge instructions and to navigate the patient back to the primary care provider for follow-up care. The Chronic Care Model transitions to a Patient Centered Medical Home with this emphasis on care coordination and self management education for chronic conditions. Physician champions promote programs targeted to improve quality measures and patient outcomes. Educational materials continue to reach a broad range of patients with chronic disease and the scope of education was broadened to include end of life care, fall risk assessment and prevention and medication reconciliation and safety. The COMPASS Disease Management Program grew in both services offered to patients and contacts by nurse disease managers with an expanded emphasis on preventive care and intervening with patients with pre-disease for diabetes and peripheral arterial disease. For more information, contact: Nan Holland, R.N. at nlholland@novanthealth.org.

Geisinger Clinic focuses on: (1) A unique implementation of the Medical Home model of care including patient-centered, team based care across the continuum, practice-integrated case management, fully revamped payment incentives, and the proactive identification of high risk patients; (2) Transitions of care coordination and case management including medication reconciliation, enhanced access for early post discharge follow-up, self-management action plans for chronic care exacerbation management, telephonic and/or device-based remote monitoring and associated order execution for beneficiaries with congestive heart failure; (3) Using its electronic health record to identify and systematically resolve care gaps to ensure comprehensive prevention and treatment of all medical conditions; (4) Automating identification, notification and scheduling of pneumococcal and influenza immunization services; and (5) Redesigned systems of care monitored by performance on "all or none" evidence-based bundles for diabetes, coronary artery disease, chronic kidney disease and adult prevention. For more information, contact: Ronald A. Paulus, M.D. at: rapaulus@geisinger.edu.

Marshfield Clinic is participating in the demonstration as a reflection of its mission to serve patients through accessible, high quality health care, research and education. The clinic expanded a number of on-going successful initiatives and accelerated the development and adoption of others including enhancements to its electronic health record to systematically expand a support structure to implement care management and coordination. Specifically, the clinic expanded its anticoagulation care management program across the entire system and developed a heart failure care management program with the goal of improving clinical care, improving quality of life and decreasing costs and hospitalizations. In addition, the clinic continues to promote use of its nurse advice line, develop clinical practice guidelines and monitor population-based clinical performance through clinical dashboards. For more information, contact: Theodore A. Praxel, M.D. at praxel.theodore@marshfieldclinic.org.

Middlesex Health System is participating in the project as a network of physicians affiliated with a community hospital. Interventions focus on processes to improve electronic linkages and communications among all providers for each patient and demonstrate quality and safety across the continuum of care. Building on a long history of close collaboration between the hospital, its medical staff and a commitment to the mission of community health improvement, the Hospital commissioned a community health assessment to identify service gaps and secure an understanding of the current and projected health needs of the service area. Services such as an inpatient COPD pathway and enhanced outpatient care for COPD patients were deployed to

close existing service gaps. Care Management programs and support services designed to educate and promote patient self- management skills around chronic diseases such as heart failure, diabetes, asthma and Nurse Navigators for cancer patients are offered. Efforts to ensure appropriate immunizations, cancer screenings, support groups, smoking cessation program availability, medication safety, innovative palliative care, and use of tele-monitoring technology are also utilized. For more information, contact: Arthur McDowell, M.D. at Arthur_McDowell_MD@midhosp.org.

Park Nicollet Health Services started an inpatient palliative care program and continues to enhance their care of patients with diabetes and heart failure. An innovative telephone monitoring program was instituted for high-risk heart failure patients. Over 560 patients with heart failure have been enrolled into an automated telephonic program to improve their quality of life. Each patient makes a daily call to provide weight and symptom reports, allowing nurse case managers at the clinic to spot early signs of deterioration and intervene in their heart failure management. Electronic patient registries are the cornerstone of management for patients with chronic disease and have been combined with Park Nicollet's existing electronic medical record. As a result, patient information can be reviewed by the physician care team prior to upcoming appointments for unmet health care needs. Another improvement was initiating same-day lab testing prior to the visit for many of these chronic disease patients. Using these steps, along with pre-visit planning, significantly increased time for important face-to-face interaction with the provider when crucial decisions need to be made about treatment. For more information, contact: Mark Skubic at Mark.Skubic@ParkNicollet.com.

St. John's Health System developed a comprehensive patient registry to respond to the demonstration's quality improvement incentives. The registry is designed to track patient information, identify gaps in care, and ensure that appropriate and timely care is provided. A key element of the patient registry is the visit planner which is designed to complement physicians' established clinical work-flow process. It provides a "to do" list for physicians prior to each patient visit, with reminders for needed tests or interventions. The visit planner consists of a one-page summary for each patient showing key demographic and clinical data, including test dates and results. An exception list highlights tests or interventions for which the patient is due and provides physicians with reports on areas where patient care can be improved. The provider/clinic manager uses the decentralized reporting feature to generate un-blinded outcome reports from the registry at both the individual provider and clinic levels. In addition, a case manager was deployed in the emergency department to collaborate with the health system and community services to provide transition planning. A heart failure team has been designated to drive the coordination of heart failure care, provider education, and increase outcome success. Special groups are being convened to focus on diabetic retinal eye exams, mammography and colorectal cancer screenings. For more information, contact: James T. Rogers, M.D. at James.Rogers@Mercy.net or Donna Smith at Donna.Smith@Mercy.net.

University of Michigan Faculty Group Practice focus on improving transitional care and complex care coordination for Medicare patients. The group's transitional care call-back program contacts Medicare patients discharged from the emergency department and acute care hospital to address gaps in care during the transition between care settings. This program also provides short-term care coordination with linkages to visiting nurse and community services

and coordination with primary care and specialty clinics. The group also developed a complex care coordination program with social workers and nurses who work with physicians to assist patients who have multiple risks, high costs and complex health status. In the hospital setting, the group developed a pharmacy facilitated discharge program for patients with high-risk medications and a palliative care consult service to work with patients and families to ease end of life transitions. In the second year of the project, these services were joined by a sub-acute service that brings geriatric faculty into local sub-acute facilities and an expanded geriatric inpatient consult service that provides expertise in geriatric medicine and transitional care. The group also has a heart failure nurse tele-management program that coordinates with its heart failure clinics. The group's quality program uses patient registries with relevant quality indicators and individual physician/provider feedback on the quality of care for their patients. For more information, contact: Caroline S. Blaum, M.D. at cblaum@umich.edu.

For More Information

The demonstration started April 1, 2005 and the fifth performance year ended March 31, 2010. As included in The Affordable Care Act, we are currently working on a transitional demonstration while the Medicare Shared Savings Program is being developed.

For additional information, visit the Physician Group Practice webpage at:

<http://www.cms.hhs.gov/DemoProjectsEvalRpts/MD>

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